Item 20&Film 217 6-28-57 ams 21

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6241 Item 7 Film 217 7-1-57 e

Reg. Dist. No. 06231 282

1. PLACE OF DEATH a. COUNTY Charles MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Colorado b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Littleton 44X-3
d. STREET ADDRESS Colorado
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First ALVIN Middle C. Last BIRZA
4. DATE OF DEATH Month 6 Day 15 Year 1957
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-9-35
9. AGE (In years last birthday) 22 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY NAVY
11. BIRTHPLACE (State or foreign country) Colorado
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles
14. MOTHER'S MAIDEN NAME UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) NAVY
16. SOCIAL SECURITY NO. 437-08-55
17. INFORMANT Address USNAS - Patuxent River, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 6-15-57
823 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Fractured Skull 6-15-57
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Riding as outside front seat passenger of 3 in a convertible. Conv. made a turn and grazed a tree as Mr. Birza's head hit tree
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 6-15 1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f. (City or town) Waldorf (County) Chas (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE F. J. Edelen M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☑
EXAMINER'S NAME (Type) F. J. EDELEN
DATE SIGNED 6-15-57

22a. BURIAL, CREMATION, REMOVAL (Specify) TRANSPORTATION
22b. DATE THEREOF 6-18-57
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) (State) DENVER, COLORADO.

23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson ADDRESS Leonardtown Md
24a. RECD BY REGISTRAR DATE 6/20/57
24b. REGISTRAR'S SIGNATURE Alan D. Hauser

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5) SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6242

CERTIFICATE OF DEATH

06232

Reg. Dist. No. 100

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Hospt

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Faulkner
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First THOMAS Middle W. Last BOWLING
4. DATE OF DEATH: Month JUNE Day 4 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept 13 1878
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Wallace T Bowling
14. MOTHER'S MAIDEN NAME: Ellen Dolman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Margaret Cooney Dentsville — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary occlusion	10 days
420.1 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Uremia - renal apoplexy	5 days
DUE TO (c)	Benign prostatic hypertrophy c obstruction	1 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Dilated myocardium Hernia c partial obstruction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 19 56, to 6-4, 19 57, that I last saw the deceased alive on 6-4, 19 57, and that death occurred at 12:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: F. M. Johnson M.D. — ADDRESS (Street, city or town, state): La Plata, Md. — DATE SIGNED: 6-5-57

PHYSICIAN'S NAME (Type): F. M. JOHNSON M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/7/57
22c. NAME OF CEMETERY OR CREMATORY: Dentsville M.E.
22d. LOCATION (City, town, or county) (State): Dentsville Md

23. FUNERAL DIRECTOR'S SIGNATURE: Wilbert Funeral Home — ADDRESS: La Plata Md

24a. REC'D BY REGISTRAR DATE: 6/10/57
24b. REGISTRAR'S SIGNATURE: Julia H Wasey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6243 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07378

Item 9 FilmG217 7-12-57 et

Reg. Dist. No. 105

1. PLACE OF DEATH
a. COUNTY Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 WALDORF
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3. NAME OF DECEASED (Type or print) First JAMES Middle LUTHER Last BUTLER

4. DATE OF DEATH Month 6 Day 29 Year 1957

5. SEX M

6. COLOR OR RACE C

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 10-15-1902

9. AGE (In years last birthday) 54 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER

10b. KIND OF BUSINESS OR INDUSTRY what ever available

11. BIRTHPLACE (State or foreign country) MD

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John BUTLER

14. MOTHER'S MAIDEN NAME GEORGIA BROWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. UNK.

17. INFORMANT Address LENNIE KENT 921 N J AVE. SE Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 6-29-57

DUE TO (b) Communted Fracture of Skull 6-29-57

DUE TO (c) Hit w Club 6-29-57

983x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit w club

20c. TIME OF INJURY Hour 9 a.m. p.m. Month, Day, Year 6-29 1957

20d. INJURY OCCURRED While at work ☐ Not while at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home

20f. (City or town) Waldorf (County) Chas. (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☑, Undetermined cause ☐.

ACTUAL SIGNATURE E. F. Edelen M.D.

EXAMINER'S NAME (Type) E. F. EDELEN MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

DATE SIGNED 7-1-57

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 7-3-57

22c. NAME OF CEMETERY OR CREMATORY John Wesley Cem.

22d. LOCATION (City, town, or county) WALDORF (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE HUNCE FUNERAL HOME ADDRESS WALDORF, Md.

24a. REC'D BY REGISTRAR DATE JUL 8 1957

24b. REGISTRAR'S SIGNATURE M. L. Mooney

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06233

6244

Reg. Dist. No. 106

1. PLACE OF DEATH

COUNTY Charles — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Indian Head Md

LENGTH OF STAY (In this place) 6 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Charles

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Indian Head Md

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) George (Middle) Carroll (Last) Casto

4. DATE OF DEATH (Month) 6-8- (Day) (Year) 57 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White-US	Married	9-22-1889	67 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hospital Attendant	Medical Care	Morgantown-West Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
UNK	UNK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	[illegible]	Wife-Mrs Geo Casto, Bryans Road Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

162X IMMEDIATE CAUSE (A) General Asthenia — INTERVAL BETWEEN ONSET AND DEATH: One Month

ANTECEDENT CAUSE(S) DUE TO (B) Bronchio-Genic Carcinoma — One Year

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cerebral Metastises — 6-Mths

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August-1 ....., 1956 ....., to 6-8-57 ....., 19 ....., that I last saw the deceased alive on 6-8-57 ....., 19 ....., and that death occurred at 2:30P M, from the causes and on the date stated above.

SIGNATURE James E Andrews M.D. **ADDRESS** (Street, city, town, state) 17-Potomac Ave Indian Head Md **DATE SIGNED** 6-8-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	June 14 1957	Pleasant Hill	Houston County Ala

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
JUN 12 1957	Mrs. Odey Price	The Hunt Funeral Home	Waldorf Md

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6245

06234

Reg. Dist. No. 100

1. PLACE OF DEATH

COUNTY: CHARLES — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA

LENGTH OF STAY (in this place): 2 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: PHYSICIANS MEMORIAL

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Md — COUNTY: CHARLES

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WICOMICO

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) CARROLL (Last) CLEMENTS

4. DATE OF DEATH: (Month) 6 (Day) 8 (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	MARRIED	Oct 19 1895	61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Storekeeper	Retail	Charles County, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert Lee Clements	Florence Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
Yes	WWI	[redacted]	Mary L. Clements Wicomico, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X IMMEDIATE CAUSE (A) INTESTINAL OBSTRUCTION — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) NEOPLASTIC PERITONITIS — 3 MOS.

DUE TO (C) ADENOCARCINOMA OF APPENDIX — 14 MOS.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-7-57	EXTENSIVE ADENOCARCINOMA - ABDOMEN	YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from APRIL, 19 56, to JUNE 8, 19 57, that I last saw the deceased alive on JUNE 8, 19 57, and that death occurred at 6:00 P.M. EST. from the causes and on the date stated above.

SIGNATURE Farran Jarboe M.D. **ADDRESS** (Street, city, town, state) La Plata Md **DATE SIGNED** 6-8-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	6-11-57	St Mary's Cem.	NEWPORT, Md.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE JUN 12 1957	Julia Posey	Huntt Funeral Home	Waldorf, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06235

Reg. Dist. No. 160

1. PLACE OF DEATH
a. COUNTY CHARLES MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRYANTOWN
c. LENGTH OF STAY IN 1b 16 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 BRYANTOWN
d. STREET ADDRESS (RURAL)
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First: WARREN Middle: LEVI Last: DENT
4. DATE OF DEATH Month: JUNE Day: 12 Year: 1957
5. SEX: MALE
6. COLOR OR RACE: W-U.S.
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: MAY 20, 1875
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. CIVIL SERVICE
10b. KIND OF BUSINESS OR INDUSTRY: FOREMAN
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: FREDERICK DENT
14. MOTHER'S MAIDEN NAME: MARY DENT
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: MRS. WARREN DENT; BRYANTOWN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC HEART DISEASE (CARDIAC FAILURE) — INTERVAL BETWEEN ONSET AND DEATH: INSTANTANEOUS
DUE TO (b) GENERALIZED ARTERIO-SCLEROSIS — 20 YRS.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
450.0

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [ ], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: John N. Griffin M.D. acting
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 6/12/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 15, 1957
22c. NAME OF CEMETERY OR CREMATORY: Old Fields
22d. LOCATION (City, town, or county) (State): Hyattsville Md

23. FUNERAL DIRECTOR'S SIGNATURE: Hewitt Funeral Home ADDRESS: Waldorf Md.
24a. REC'D BY REGISTRAR DATE: JUN 17 1957
24b. REGISTRAR'S SIGNATURE: Julia Posey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06236

CERTIFICATE OF DEATH

6247 Item 7 FilmG216 6-19-57 et

Reg. Dist. No. 100

1. PLACE OF DEATH

COUNTY Charles — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Charles

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road, Md.

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) William A. (Middle) (Last) Dyson

4. DATE OF DEATH (Month) June (Day) 15 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
male	Col.	Widowed		78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired		Maryland	U. S.

13. FATHER'S NAME Sidney Dyson

14. MOTHER'S MAIDEN NAME Sophie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give wer or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS Hattie L. King Wash. DC.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Hemorrhage into meninges — INTERVAL BETWEEN ONSET AND DEATH 5 day

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12 Jan 19 57, to 15 Jan 19 57, that I last saw the deceased alive on 14 Jan 19 57, and that death occurred at 8-20 P.M., from the causes and on the date stated above.

SIGNATURE [signature] M. D. **ADDRESS** (Street, city, town, state) La Plata, Md. **DATE SIGNED** 6-15-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6-19-57	Metropolitan M. E.	Pomonkey Md.

24. REC'D BY REGISTRAR DATE JUN 17 1957	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
	Julia Posey	Barnes & Matthews	614-4th St. S.E.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06237

6248 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10-6

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY: Charles — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE: Maryland b. COUNTY: Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Potomac Heights
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Dispensary Indian Head Md	d. STREET ADDRESS: 56 Elder Place — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Edward	Milton	Forestell	June	13	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		1-5-96	61 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Catering Service	Civ. Serv. (Ret)	Baltimore Md	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Forestell	Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES	World War I	220326172	Mrs E M. Forestell, Indian Head. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)	Coronary Occlusion	5 min.
DUE TO (b)	Chronic Myocarditis	2yrs.
DUE TO (c)		

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying couse last. 420.1 422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Had Coronary Occlusion 2 years ago and was under treatment

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): Nov 18

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify thot I taak charge of the remains described obove, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that deoth resulted from: Natural couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined couse ☐.

ACTUAL SIGNATURE: Frank A. Susan M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 6-13-57

EXAMINER'S NAME (Type): Frank A. Susan M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Buried	6/19/57	Arlington Natl.	Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
W. W. Chambers Co. Washington D.C.	6/13/57	Odey Price

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6249 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06238

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ripley
c. LENGTH OF STAY IN 1b: 1 yr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Chas —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ripley ×2
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First SANDRA Middle ROBBIN Last GILROY

4. DATE OF DEATH: Month 6 Day 26 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 5-31-56

9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Dec

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Floyd Collins Gilroy

14. MOTHER'S MAIDEN NAME: Dorothy Mae Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6-26-57
DUE TO (b): Crushed Skull — 6-26-57
DUE TO (c): Truck ran over head — 6-26-57

830x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Truck backed over its head Child at play
20c. TIME OF INJURY Hour 12 p. m. Month, Day, Year 6-26 1957
20d. INJURY OCCURRED White at work ☐ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Ripley (County) Chas (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E J Edelen M.D.
EXAMINER'S NAME (Type): E. J. EDELEN
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 6-26-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-29-57
22c. NAME OF CEMETERY OR CREMATORY: Mt Rest
22d. LOCATION (City, town, or county) (State): La Plata Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Graham-Inc
ADDRESS: La Plata Md.
24a. REC'D BY REGISTRAR DATE: 7/1/57
24b. REGISTRAR'S SIGNATURE: Julia H Posey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06239

CERTIFICATE OF DEATH

6250

Reg. Dist. No. 100

1. PLACE OF DEATH

COUNTY Charles Co — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laplata md — LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Hospt

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE — COUNTY Charles

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton Md.

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Infant (Middle) (Last) Mills Harvey

4. DATE OF DEATH (Month) June (Day) 14 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	Col		June 13 1957	yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Charles Co Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Leonard Harvey

14. MOTHER'S MAIDEN NAME Ann Mills

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS Leonard Harvey

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

764.0 IMMEDIATE CAUSE (A) Resp Disorder — INTERVAL BETWEEN ONSET AND DEATH 6 hrs & 7

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.

SIGNATURE [signature] M.D. **ADDRESS** (Street, city, town, state) **DATE SIGNED**

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Buried	6-17-57	Crime Property	Bel Alton Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
6/18/57	Julia H Posey	Orchard Inc	Laplata md.

4000141XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6251 — 06240 — Reg. Dist. No. 105

1. PLACE OF DEATH — a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): White Plains
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: md — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): White Plains
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LARY — Middle ELROY — Last HAWKINS
4. DATE OF DEATH: Month 6 — Day 28 — Year 19 57
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-4-17
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months — Days 2 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): white Plains md
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: WARREN A HAWKINS
14. MOTHER'S MAIDEN NAME: EDNA CAMPBELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Warren Hawkins white Plains md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Strangulation — INTERVAL BETWEEN ONSET AND DEATH: 6-28-57
DUE TO (b): Aspiration of Vomitus — 6-28-57
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 762.0
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour 6 a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED — While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) White Plains (County) Charles (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): E. H. EDELEN, M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6-28-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/29/57
22c. NAME OF CEMETERY OR CREMATORY: St Joseph
22d. LOCATION (City, town, or county): Pomfret (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hunt Funeral Home — ADDRESS: Waldorf Md
24a. REC'D BY REGISTRAR — DATE: JUL 2 1957
24b. REGISTRAR'S SIGNATURE: M. L. Monroe

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

4000310XV6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6252

CERTIFICATE OF DEATH

Reg. Dist. No. 06241

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WALDORF
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 WALDORF
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DONALD — Middle LEE — Last HOOD

4. DATE OF DEATH: Month JUNE — Day 15 — Year 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 6 1945

9. AGE (In years last birthday): 12 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): school

10b. KIND OF BUSINESS OR INDUSTRY: school

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: JAMES HOOD

14. MOTHER'S MAIDEN NAME: MAE PEARSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. MAE GORDON — Address: WALDORF, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage, Pulmonary — INTERVAL BETWEEN ONSET AND DEATH

145 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Carcinomatosis

DUE TO (c): Cancer - Primary of Tonsils

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb - , 19 50, to June 15, 19 57, that I last saw the deceased alive on June - 15, 19 57, and that death occurred at 6 - P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. C. Weber M.D. — ADDRESS (Street, city or town, state): Waldorf Md — DATE SIGNED: 6-17-57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 6-13-57

22c. NAME OF CEMETERY OR CREMATORY: St. Pauls Cemetery

22d. LOCATION (City, town, or county) (State): Waldorf, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Huntt Funeral Home — ADDRESS: Waldorf, Md.

24a. RECD BY REGISTRAR DATE: JUN 19 1957

24b. REGISTRAR'S SIGNATURE: M. L. Monroe

Items 2&18 Film 218 7-26-57 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06242

6253

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: ~~Charles~~ Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Accokeek
d. STREET ADDRESS: 16X0.2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First EUGENE — Middle CLARENCE — Last INGRAHAM

4. DATE OF DEATH: Month June — Day 19 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/2/1912

9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Parts Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Auto

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward D. Ingraham

14. MOTHER'S MAIDEN NAME: Emma L. Tower

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 578 01 2008

17. INFORMANT: Mireta R. Ingraham — Address: 1606 17st, SE Wash., D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fatty Liver — INTERVAL BETWEEN ONSET AND DEATH:
581.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Paul Guerin M.D.

EXAMINER'S NAME (Type): Paul F. Guerin, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 6/19/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-22-57
22c. NAME OF CEMETERY OR CREMATORY: St Paul's
22d. LOCATION (City, town, or county) (State): Waldorf, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The Huntt Funeral Home — ADDRESS: Waldorf, Md.

24a. REC'D BY REGISTRAR — DATE: JUN 25 1957

24b. REGISTRAR'S SIGNATURE: M. L. Mowrey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6254 — 07384 — Item 2 Film G217 7-12-57 et — Reg. Dist. No. 100

1. PLACE OF DEATH
a. COUNTY: Charles. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt Victoria
c. LENGTH OF STAY IN 1b: 1/2 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C. 47X-3
d. STREET ADDRESS: 1506 "R" St., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RICHARD Middle F Last Jones JR
4. DATE OF DEATH: Month 6 Day 30 Year 1957

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 6 1919
9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laytary Dept
10b. KIND OF BUSINESS OR INDUSTRY: D.C. Govt
11. BIRTHPLACE (State or foreign country): DC
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard E. Jones Sr.
14. MOTHER'S MAIDEN NAME: Margaret Leslie Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning — Interval between onset and death: 6-30-57
DUE TO (b): Capsized Boat — 6-30-57
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
850.X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Boy Capsized
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year: 6-30 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): River
20f. (City or town) (County) (State): Potomac River Charles

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E J Edelen M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
EXAMINER'S NAME (Type): E. J. EDELEN M.D.
DATE SIGNED: 7-4-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-5-57
22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet
22d. LOCATION (City, town, or county) (State): Washington D C.

23. FUNERAL DIRECTOR'S SIGNATURE: Orchard Inc
ADDRESS: Coplata md.
24a. REC'D BY REGISTRAR DATE: 7/6/57
24b. REGISTRAR'S SIGNATURE: Julia H Raney

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06243

6255 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY: Charles — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marbury c. LENGTH OF STAY IN 1b: d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):	2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE: Maryland b. COUNTY: Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Marbury d. STREET ADDRESS: 1 e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
GEORGE	(SIMONS)	MADDOX	June	16	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Colored		June 9 1932	25 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fisherman	Factory	Pilley Md	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Simons	Elizabeth Maddox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
		Joseph Simons Marbury Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning, Found Drowned. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
	Found drowned.

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
3:00 P. m.	6/15 1957		Mattawoman Creek	Near Indian Head Charles Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☒.

ACTUAL SIGNATURE: Paul F Guerin M.D.

EXAMINER'S NAME (Type): Paul F. Guerin, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 6/17/57

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	6/18/57	Smyths Chapel	Bryan Md

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Richard Inc Baptist		6/18/57	Julia M Posey

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06244

6256 CERTIFICATE OF DEATH

Reg. Dist. No. 106

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: Charles — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: —

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Charles

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head

STREET ADDRESS (If rural give location): —

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Joseph (Last) MATTINGLY

4. DATE OF DEATH: (Month) June (Day) 26, (Year) 19 57

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	May 10, 1872	85 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
U. S. Gov.	Ret.	New York	US.

13. FATHER'S NAME: John T. Mattingly

14. MOTHER'S MAIDEN NAME: Eliz. E. Franklin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): No. (If Yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Mary E. Mattingly Indian Head, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.0 IMMEDIATE CAUSE (A)	Respiratory failure	1 day
ANTECEDENT CAUSE(S) DUE TO (B)	Cerebral vascular accident	2 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	Arterio sclerosis heart disease	10 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	331X	YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1957, to June, 1957, that I last saw the deceased alive on 26 June 1957, and that death occurred at 12:20 P.M. EST, from the causes and on the date stated above.

SIGNATURE: [signature] M.D. ADDRESS (Street, city, town, state): La Plata. Md DATE SIGNED: 26 June 57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6-29-57	St Joseph's Cem.	Pomfret, Md.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE JUL 1 1957	[signature]	The Huntt Funeral Home	Waldorf, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06049

Reg. Dist. No. 100

Item 9 Film G216 6-17-57 et

1. PLACE OF DEATH
a. COUNTY Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata Md
c. LENGTH OF STAY IN 1b 4 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Mem. Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Gr. Res.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 16152
d. STREET ADDRESS 7509-25th Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MARGARET Middle Mc Last MANNIS
4. DATE OF DEATH Month 6 Day 8 Year 1957
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug 7 1916
9. AGE (In years last birthday) 40 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H W.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) W Va
12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME Lloyd C McCauley
14. MOTHER'S MAIDEN NAME Bertha Rosella Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 577-42-6103
17. INFORMANT Glynn A. McMANNIS Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	
816X DUE TO (b)	Abdominal Hemorrhage	6-8-57
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c)	Multiple Lacerations & Contusions	6-8-57
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	Auto accident	

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2 car auto accident
20c. TIME OF INJURY Hour 1:00 a.m. p.m. Month, Day, Year 6 8 1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 301 highway
20f. (City or town) Waldorf (County) Chas (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE H. Edelen M.D.
EXAMINER'S NAME (Type) H. J. EDELEN
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 6-8-57

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 6-13-57
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln
22d. LOCATION (City, town, or county) Colmar Manor (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington ADDRESS
24a. REC'D BY REGISTRAR DATE JUN 12 1957
24b. REGISTRAR'S SIGNATURE Julia Posey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06245

CERTIFICATE OF DEATH

6258

Reg. Dist. No. 100

1. PLACE OF DEATH

COUNTY Charles — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata Md

LENGTH OF STAY (in this place): 3-days

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Physicians Memorial Hosp. La Plata Md.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Charles

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indian Head Md.

STREET ADDRESS (If rural give location): 11-Irwin Place Potomac Heights

3. NAME OF DECEASED (Type or Print) (First) Dora (Middle) Posey (Last)

4. DATE OF DEATH (Month) 6-14-57 (Day) (Year) 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F.	W-US	Single	2-13-1870	87 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	None	Charles County Maryland	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Henry Posey	Susan Julia Posey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	None	Doris Morgan Hedges, 14-E-60th St. New York City

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420,1 IMMEDIATE CAUSE (A) Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10-Yrs

ANTECEDENT CAUSE(S) DUE TO (B) Arterio-Sclerosis — Indefinite

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Senility

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1954, to 6-14-57, 19, that I last saw the deceased alive on 6-14-57, 19, and that death occurred at 5-15 PM from the causes and on the date stated above.

SIGNATURE James E. Andrews M.D. M.D. — ADDRESS (Street, city, town, state): 17-Potomac Ave Indian Head Md — DATE SIGNED: 6-15-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6-17-57	St. Charles	Hilmont md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
6/18/57	Julia H Posey	Chas Thompson	La Plata Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6259 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06246

Item 7 Film 6217 6-28-57 et.

Reg. Dist. No. 100

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b: 1 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)
a. STATE: Fo. Carol
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Georgetown 77 x 3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LeRoy Middle Last Reed

4. DATE OF DEATH: Month 6 Day 14 Year 1957

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-24-29

9. AGE (In years last birthday): 27 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Planer

11. BIRTHPLACE (State or foreign country): Georgetown S.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frances Reed

14. MOTHER'S MAIDEN NAME: Louise Conyers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage
DUE TO (b): Stab wound of Chest
DUE TO (c): Cutting one of the great Vessel or Heart

INTERVAL BETWEEN ONSET AND DEATH: 6-14-57

982x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Stabbed by assailant

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): La Plata Chas. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE: E. Edelen M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): E. J. EDELEN M.D.

DATE SIGNED: 6-15-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-20-57

22c. NAME OF CEMETERY OR CREMATORY: Georgetown

22d. LOCATION (City, town, or county) (State): Georgetown S.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Herbert Rice

ADDRESS: La Plata Md.

24a. REC'D BY REGISTRAR DATE: 6/20/57

24b. REGISTRAR'S SIGNATURE: Julian H. Posey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06247

6260 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 100

1. PLACE OF DEATH
a. COUNTY Charles MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Piney Hill
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Ohio b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Defiance 72 x 3
d. STREET ADDRESS 725 Wayne Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3. NAME OF DECEASED (Type or print) First Thomas Middle Michael Last Ryan
4. DATE OF DEATH Month 6 Day 8 Year 1957
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 7-8-31
9. AGE (In years last birthday) 25 yrs.
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) M/Sgt.
10b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Daniel Francis Ryan
14. MOTHER'S MAIDEN NAME Leona Margaret (illegible)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) Yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Capt T. E. Bell Address Bolling A.F.B. Wash D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH: 6-8-57

DUE TO (b) Crushed Chest — 6-8-57

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Auto accident

816X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car Collision, auto
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rte 361
20f. (City or town) (County) Defiance (State) Ohio

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. Edelen M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) F. E. EDELEN IV M.D.
DATE SIGNED 6-8-57

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 6-10-57
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) (State) Defiance, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. W. Chambers Co. 517-11th St S.E.
24a. REC'D BY REGISTRAR DATE JUN 12 1957
24b. REGISTRAR'S SIGNATURE Julia Posey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06248

6261

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH

COUNTY: Charles — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Charles

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Rock Point, Md.

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) John W. (Middle) (Last) Shorter

4. DATE OF DEATH: (Month) June (Day) 14 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	White	Widower	Sept 30 1873	83 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ret. farmer		Maryland	U. S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John W. Shorter	Elizabeth Long

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
			Mrs. Nichols Washington D.C.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X IMMEDIATE CAUSE (A) Congestive Heart Failure — Interval between onset and death: 1 yr.

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertension — 7

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at .....M, from the causes and on the date stated above.

SIGNATURE [signature] M.D. — ADDRESS (Street, city, town, state) — DATE SIGNED 6-15-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6/17/57	Holy Ghost	Issue Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
6/18/57	Julia H Casey	Crickett Inc Leonardtown Md	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6262

07392

Reg. Dist. No. 702

1. PLACE OF DEATH a. COUNTY Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ironsides
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Ironsides
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last: LAWRENCE E. STAFFORD
4. DATE OF DEATH: Month 6 Day 30 Year 19 57

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W		Nov 23, 1904	52 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Writer	Financial	Minnesota	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harry H. Stafford	Edith Bayley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WWII	363-05-3857	Mary M. Stafford (Wife), Ironsides, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 6-30-57
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. J. Edelen M.D.
EXAMINER'S NAME (Type) E. J. EDELEN
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 6-30-57

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	7/3/57	Arlington National	Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE Joseph Howard & Son ADDRESS 1756 Pennsylvania Ave NW, Washington, DC
24a. REC'D BY REGISTRAR DATE July 5 1957
24b. REGISTRAR'S SIGNATURE V Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06249

6263

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH

COUNTY Charles — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road

LENGTH OF STAY (in this place) 20 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md. COUNTY Charles

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) — (First) Robert (Middle) (Last) Thomas

4. DATE OF DEATH (Month) June (Day) 2 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Colored	Widowed	March 17, 1848	109 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farm	Port Tobacco, Md	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Not Known	Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		None	Gracie Thomas. Washington DC

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 3 wks.

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 8, 1957, to June 2, 1957, that I last saw the deceased alive on June 1, 1957, and that death occurred at 8 P.M., from the causes and on the date stated above.

SIGNATURE Frank L Posan M.D. **ADDRESS** (Street, city, town, state) Indian Head, Md **DATE SIGNED** 6-2-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	June 5 1957	Maccloma Baptist	Bryans Road Md

24. REC'D BY REGISTRAR DATE JUN 7 1957	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
	Julia Posey	Hoxtt Funeral Home	Waldorf Md

BR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 2,11,12 See Birth Cert. et
6264 Item 1 Film 6217 6-24-57 et

06250
Reg. Dist. No. 100

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): En-route to La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Auto enroute

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO McConchie
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Tyronne — Middle: — Last: Thomas

4. DATE OF DEATH: Month: 6 — Day: 3 — Year: 1957

5. SEX: M

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-4-57

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): McConchie, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alvin Thomas

14. MOTHER'S MAIDEN NAME: Mary Florence Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: 6-1-57
571.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. J. Edelen M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): E. J. EDELEN
DATE SIGNED: 6-3-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June 4 1957
22c. NAME OF CEMETERY OR CREMATORY: Prop. of Richard Thomas
22d. LOCATION (City, town, or county) (State): MC Conchie Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Orehart Inc
ADDRESS: Loplata md
24a. REC'D BY REGISTRAR DATE: 6/10/57
24b. REGISTRAR'S SIGNATURE: Julia H Posey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

4000256XV6

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6265 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06251

Reg. Dist. No. 100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hughesville (Rural)
c. LENGTH OF STAY IN 1b: 0
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md. b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Hughesville (Rural)
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle Lost TOYE
4. DATE OF DEATH: Month 6 - 9 Day Year 1957
5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1903
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): maid
10b. KIND OF BUSINESS OR INDUSTRY: domestic
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William W. Toye
14. MOTHER'S MAIDEN NAME: Jane Estep

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: unk
17. INFORMANT: DeSales B. Toye, Address: Hughesville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): STAB WOUND OF AORTA — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

982x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE: R S Fisher M.D.
EXAMINER'S NAME (Type): R. S. FISHER
CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 6/9/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-12-57
22c. NAME OF CEMETERY OR CREMATORY: St Mary's Cem.
22d. LOCATION (City, town, or county) (State): Bryantown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The Huntt Funeral Home ADDRESS: Waldorf, Md.
24a. REC'D BY REGISTRAR DATE: 6/12/57
24b. REGISTRAR'S SIGNATURE: Julia Posey

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

06252

6266

CERTIFICATE OF DEATH

Reg. Dist. No. 100

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: CHARLES — STATE: MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: LA PLATA — LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: PHYSICIANS' MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: MARYLAND — COUNTY: CHARLES

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: LA PLATA

STREET ADDRESS (If rural give location): WICOMICO STREET

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) BERNADETTE (Last) WALKER

4. DATE OF DEATH: (Month) JUNE (Day) 28 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
FEMALE	W-U.S.	SINGLE	JUNE 26, 1957	— yrs.	—	1	10	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	MARYLAND	US

13. FATHER'S NAME: THOMAS JEFFERSON WALKER

14. MOTHER'S MAIDEN NAME: ESTELLA ELIZABETH HUNTT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
NO		~~NONE~~	THOMAS J. WALKER LA PLATA, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
761.5 IMMEDIATE CAUSE	(A) EXCESSIVE PREMATURITY (EDC - 10/12/57)	34 hrs
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) MALDEVELOPMENT OF CENTRAL NERVOUS	34 hrs
	DUE TO (C) SYSTEM	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. MARGINAL PLACENTA PREVIA (MATERNAL)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/26, 19 57, to 6/28, 19 57, that I last saw the deceased alive on 6/28, 19 57, and that death occurred at 6:50 A M, from the causes and on the date stated above.

SIGNATURE	M.D.	ADDRESS (Street, city, town, state)	DATE SIGNED
John N. Griffin		Hughesville Md.	6/28/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	6-28-57	St Peters Cem.	WALDORF, Md.

24. REC'D BY REGISTRAR (DATE)	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
JUL 1 1957	Julia Posey	Hunt Funeral Home	Waldorf, Md.

2066263XVO

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06253

6267

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH

COUNTY: Charles — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata

LENGTH OF STAY (In this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Charles

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac Heights, Md.

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) JOSEPH (Middle) WILLIAM (Last) WHITE

4. DATE OF DEATH: (Month) June (Day) 12 (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	col		April 18/57	~~xxxxx~~ yrs.	2			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Md	

13. FATHER'S NAME: Lawrence White

14. MOTHER'S MAIDEN NAME: Alice Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
	[redacted]	

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

571.0 IMMEDIATE CAUSE (A) diarrhea + dehydration — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSE(S) DUE TO (B) pneumonia — 3 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 493X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-12, 19 57, to 6-12, 19 57, that I last saw the deceased alive on 6-12, 19 57, and that death occurred at 7:50 M, from the causes and on the date stated above.

SIGNATURE [signature] M.D. **ADDRESS** (Street, city, town, state) La Plata Md **DATE SIGNED** 6-12-57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	6/12/57	Old Grove Baptist Church Cemetery	Nanjemoy Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
6/12/57	Julia H Posey	Father	

4000297XVC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06254

6268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 Film0216 6-19-57 et

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jeffrey Hill
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edwardsville Pa
d. STREET ADDRESS #7 Plymouth 75X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First JAMES Middle EDWARD Last WILSON
4. DATE OF DEATH Month 6 Day 8 Year 1957
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10-24-30
9. AGE (In years last birthday) 26 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sol.
10b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.
11. BIRTHPLACE (State or foreign country) Edwardsville, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Wilson
14. MOTHER'S MAIDEN NAME Ruth Elmer ( )

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Address Cpl. L.E. Bell, Bolling A.F. Base

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture base of skull — INTERVAL BETWEEN ONSET AND DEATH
816X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b) Crushed Chest — 6-8-57
DUE TO (c) Auto accident — 6-8-57

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) V Car Collision auto
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rte 301
20f. (City or town) (County) Chas. (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE C. Edelen M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) F. J. EDELEN MD
DATE SIGNED 6-8-57

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 6-10-57
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) (State) Edwardsville, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. ADDRESS 517-11th St. S.E.
24a. REC'D BY REGISTRAR DATE JUN 11 1957
24b. REGISTRAR'S SIGNATURE Julia Posey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55